

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Carroll Health and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 307 N Castleman St Oak Grove, LA 71263	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829</p> <p>Based on record reviews and interviews, the facility failed to protect the residents' right to be free from verbal and mental abuse for 1 (#4) of 5 (#1, #2, #3, #4, #5) sampled residents.</p> <p>Findings:</p> <p>Review of the facility's Abuse Prevention Policy dated 07/2024 revealed in-part:</p> <p>Policy: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardian, surrogates, friends, or any other individual.</p> <p>Definitions:</p> <p>a) Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychological well-being. Abuse may be resident-to-resident, staff-to- resident, family-to-resident, or visitor-to-resident.</p> <p>b) Verbal abuse: The use of oral, written, or gestured communication or sounds that willfully includes disparaging terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.</p> <p>e) Mental abuse: The use of verbal and nonverbal conduct which causes or has caused the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation including staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s).</p> <p>Resident #4</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review revealed resident #4 was admitted to the facility on [DATE] with diagnoses that included type 1 diabetes mellitus with foot ulcer, diabetic neuropathy, end stage renal disease, dependence on renal dialysis, anemia in chronic kidney disease, insomnia, depression, atherosclerotic heart disease of native coronary artery disease without angina, hypertension, muscle weakness (generalized) unspecified lack of coordination, abnormal posture, unsteadiness on feet, unspecified abnormalities of gait and mobility, constipation, gastroesophageal reflux disease with esophagitis, and acquired absence of right leg below knee.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated resident #4 was cognitively intact for daily decision making. Further review revealed resident #4 required substantial/maximal assistance with toileting, transfers, showering and required moderate assistance with personal hygiene and dressing. Resident #4 was occasionally incontinent of bowel and bladder. Resident #4 was unable to walk and used the manual wheel chair for ambulation.</p> <p>Resident #1</p> <p>Record review revealed resident #1 was admitted to the facility on [DATE] with diagnoses that included paraplegia, four stage 4 pressure ulcers, unspecified anemia, decreased white blood count, other thrombocytopenia, pain in unspecified joint, neuromuscular dysfunction of bladder, hypomagnesemia, and major depressive disorder.</p> <p>Review of End of Therapy MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated cognitively intact for daily decision making. Further review revealed resident #1 was independent with bed mobility, independent with transfers - required set up help only, independent with eating - required set up help only, and independent with toilet use - required set up help only.</p> <p>Review of the care plan for resident #1 revealed: have the potential to be verbally aggressive toward other residents related to poor impulse control. The goal: will demonstrate effective coping skills through the review date. Interventions include the following: Administer medications as ordered. Monitor/document for side effects and effectiveness. Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Ask resident to report to nursing staff any problems with other residents before calling parish authorities to report conflict. Assess and anticipate resident's understanding of situation. Allow time for the resident to express self and feelings towards the situation. Give the resident as many choices as possible about care and activities. Provide positive feedback for good behavior. Remove/redirect resident from escalating conversations with staff and other residents, use calming techniques to reduce agitation. Emphasize the positive aspects of compliance. Psychiatric/Psychogeriatric consult as indicated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of progress note dated 08/25/2024 at 12:45 a.m. revealed resident #1 entered dining area where resident #4 was on gaming monitor wearing ear phones. Resident #1 turned music on high volume on television set. Resident #4 asked resident #1 to turn down music before S9 Licensed Practical Nurse (LPN) entered dining room area. Resident #1 started cursing resident #4. When S9LPN entered the dining room area, she asked both residents to lower their voices and explained other residents were sleeping. Resident #1 trying to goad resident #4 into a physical altercation stating he was P*ssy and not about that life. Resident #4 tried to leave dining room area as resident #1 continued to curse and scream at resident #4. S9LPN then explained to resident #1 there was a way to resolve an issue without cursing other residents or trying to escalate the situation until there is a physical altercation. And if there was no resolve but screaming and cursing I would have no other option than to alert the authorities. Resident #1 voice understanding and remained in the dining room.</p> <p>On 09/16/2024 at 8:05 a.m., an interview with S2Director of Nursing (DON) revealed resident #1 was discharged from the facility on 09/12/2024 and he was not expected to return to the facility.</p> <p>During an interview on 09/16/2024 at 10:30 a.m., resident #4 reported on 08/25/2024 sometime after midnight he was playing on the computer that was in the hallway by the nurse's station when resident #1 came up the hallway playing loud rap music on his cell phone. Resident #4 revealed he asked the nurse if she could ask him to turn the music down. Resident #4 reported resident #1 asked him if he was wanting to fight. Resident #4 reported he did not reply to resident #1, went to the main dining room area, started playing a game on the computer and put his head his head phones on. Resident #4 reported not long after that, resident #1 came in the main dining room and turned the music on high volume through the smart television. Resident #4 asked resident #1 if he could turn the music down. Resident #4 revealed resident #1 responded by saying what does it matter you have head phones on. Resident #4 reported resident #1 started yelling at him and called him a p*ssy *ss n*gger. Resident #4 reported resident #1 verbally threatened to whoop his *ss, but did not touch him. Resident #4 reported this to S9LPN. S9LPN intervened and asked resident #1 to turn the volume down because it was late and other residents were trying to sleep. Resident #4 revealed S9LPN threatened to call the police if we did not stop yelling at each other. Resident #4 revealed S9LPN instructed for us to stay apart from one another. Resident #4 reported resident #1 continued to yell and curse at him as he left out of the dining room area. Resident #4 reported resident #1 remained in the dining room listening to his music.</p> <p>Further interview with resident #4 revealed one day last weekend (09/07/2024 or 09/08/2024) around 3:30 p. m., he was waiting on S11Certified Nursing Aide (CNA) to return to his room to clean him up and change his brief. Resident #4 revealed S11CNA had gone to go get supplies and was coming back to assist him. Resident #4 reported resident #1 came to the door of his room and told him that he stunk and smelled like poo poo. Resident #4 revealed resident #1 told him you done sh*t yourself and you should be cleaning your own booty. Resident #4 reported resident #1 called him sh*tty boy. Resident #4 reported he notified S11CNA about what resident #1 had told him when she returned to his room to provide incontinent care and change his brief. Resident #4 reported he had not told anyone else about this incident with resident #1 until 09/10/2024 when he informed S5Social Worker.</p> <p>Surveyor asked resident #4 how these two incidents with resident #1 made him feel. Resident #4 reported it made uncomfortable and mad that resident #1 would call him those names, harass him, and pick at him about his condition. Resident #4 reported he was not scared of resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/16/2024 at 11:45 a.m., an interview with S10LPN revealed she worked the night shift on 08/25/2024 and resident #1 was listening to loud rap music on his cell phone in the hallway. S10LPN reported resident #4 was playing on the computer that was located on the hallway by the nurse's station. S10LPN reported she asked resident #1 to turn his music down because there were residents who were asleep. S10LPN reported resident #4 left the computer and went to the main dining room area. S10LPN reported she went to the main dining room a few minutes later to check on resident #4 and observed resident #1 yelling and cursing at resident #4 and threatening to whoop his *ss. S10LPN reported she heard resident #1 call resident #4 a b*tch *ss n*gger, and that he was always complaining like a little b*tch. S10LPN reported S9LPN was already in the dining room and had to intervene to calm them both down. S10LPN reported she immediately called and notified S2DON of the incident.</p> <p>Surveyor asked S10LPN if she was aware of any other occurrences where resident #1 had been verbally abusive to resident #4. S10LPN reported she could not remember the exact day but it was on a Saturday or Sunday (09/7/2024 or 09/08/2024) around 3:30 p.m. S11CNA informed S10LPN that resident #4 reported resident #1 came to his door of his room and told him that he stinks, look at you sh*tting yourself like a little baby, and even my little child knows to go to the bathroom. S10LPN reported she did not document conversation but revealed she informed S3Registered Nurse (RN).</p> <p>During a telephone interview on 09/16/2024 at 3:18 p.m., S9LPN reported on 08/25/2024 around 12:45 a.m. she was at the nurse's station that is located by the dining room. S9LPN reported resident #4 was already in the dining room playing a game on the computer with his headphones on and resident #1 came in dining room and turned the music on very loud on the smart television in the dining room. S9LPN reported she immediately went to ask resident #1 to turn down the volume on the television because it was too loud and residents were trying to sleep. S9LPN reported as she entered the dining room, resident #4 was asking resident #1 to turn down the volume. S9LPN reported resident #1 started yelling and cursing resident #4. S9LPN reported resident #1 called resident #4 a p*ssy *ss n*gger and was taunting resident #4 and threatening to whoop his *ss. S9LPN reported she intervened and made sure they stayed separated. S9LPN reported she told both of them if they could not stop yelling and calm down, she would have to call the police. S9LPN reported resident #4 left the main dining room and resident #1 stayed in the dining room listening to his music at an acceptable volume.</p> <p>On 09/16/2024 at 10:30 a.m., an interview with S5Social Worker revealed resident #4 came to her office on 09/10/2024 around 2:00 p.m. S5Social Worker revealed resident #4 was reporting that resident #1 was wheeling up to his room, pushing his door open without knocking, harassing him with curse words, and making fun of him that he smells like poop and about his condition. Resident #4 further complained about resident #1 playing loud disruptive music, bowing up to him and saying bad things to him. Resident #1 makes verbal threats by saying he will beat his *ss and the cops. S5Social Worker reported she immediately notified S1Administrator on 09/10/2024 around 2:20 p.m. after talking with resident #4 and initiating a grievance related to resident #4's alleged allegations of how resident #1 was treating him. S5Social Worker further reported she and S1Administrator met with resident #1 personally on 09/10/2024 at 4:30 p.m. to investigate the alleged allegations reported by resident #4. S5Social Worker reported resident #1 did not deny the alleged allegations and reported he was trying to be nice to resident #4.</p> <p>On 09/17/2024 at 1:30 p.m., an interview with S1Administrator confirmed resident #1 caused verbal abuse and mental abuse to resident #4 on the two separate occasions.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829</p> <p>Based on record review and interviews, the provider failed to: 1) ensure an alleged violation involving verbal and mental abuse witnessed by staff was reported immediately to the Administrator and Director of Nursing and 2) ensure all allegations of verbal abuse/mental abuse were reported immediately, but no later than 2 hours after the allegation was made to State Survey Agency in accordance with State Laws for 1 (#4) of 5 (#1, #2, #3, #4, #5) sampled residents.</p> <p>Findings:</p> <p>Review of the facility's current Abuse Prevention Policy dated 7/2024 revealed in-part:</p> <p>Policy: The Facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardian, surrogates, friends, or any other individual.</p> <p>Definitions:</p> <p>a) Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychological well-being. Abuse may be resident-to-resident, staff-to- resident, family-to-resident, or visitor-to-resident.</p> <p>b) Verbal abuse: The use of oral, written, or gestured communication or sounds that willfully includes disparaging terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.</p> <p>e) Mental abuse: The use of verbal and nonverbal conduct which causes or has caused the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation including staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s).</p> <p>Identification:</p> <p>2. The Executive Director and Director of Nursing Services must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Executive Director and Director of Nursing Services must be called at home or must be paged and informed of such incident.</p> <p>Reporting:</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the event that cause the allegation involve abuse or results in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and other state officials (including State Survey Agency, Adult Protection Services (APS), and local law enforcement as required). Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency within 5 working days of the incident.</p> <p>Record review revealed resident #4 was admitted to the facility on [DATE] with diagnoses that included type 1 diabetes mellitus with foot ulcer, diabetic neuropathy, end stage renal disease, dependence on renal dialysis, anemia in chronic kidney disease, insomnia, depression, atherosclerotic heart disease of native coronary artery disease without angina, hypertension, muscle weakness (generalized) unspecified lack of coordination, abnormal posture, unsteadiness on feet, unspecified abnormalities of gait and mobility, constipation, gastroesophageal reflux disease with esophagitis, and acquired absence of right leg below knee.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated resident #4 was cognitively intact for daily decision making. Further review revealed resident #4 required substantial/maximal assistance with toileting, transfers, showering and required moderate assistance with personal hygiene and dressing. Resident #4 was occasionally incontinent of bowel and bladder. Resident #4 was unable to walk and used the manual wheel chair for ambulation.</p> <p>During an interview on 09/16/2024 at 10:30 a.m., resident #4 reported on 08/25/2024 sometime after midnight he was playing on the computer that was in the hallway by the nurse's station when resident #1 came up the hallway playing loud rap music on his cell phone. Resident #4 revealed he asked the nurse if she could ask him to turn the music down. Resident #4 reported resident #1 asked him if he was wanting to fight. Resident #4 reported he did not reply to resident #1, went to the main dining room area, started playing a game on the computer and put his head his head phones on. Resident #4 reported not long after that, resident #1 came in the main dining room and turned the music on high volume through the smart television. Resident #4 asked resident #1 if he could turn the music down. Resident #4 revealed resident #1 responded by saying what does it matter you have head phones on. Resident #4 reported resident #1 started yelling at him and called him a p*ssy *ss n*gger. Resident #4 reported resident #1 verbally threatened to whoop his *ss, but did not touch him. Resident #4 reported this to S9Licensed Practical Nurse (LPN). S9LPN intervened and asked resident #1 to turn the volume down because it was late and other residents were trying to sleep. Resident #4 revealed S9LPN threatened to call the police if we did not stop yelling at each other. Resident #4 revealed S9LPN instructed for us to stay apart from one another. Resident #4 reported resident #1 continued to yell and curse at him as he left out of the dining room area. Resident #4 reported resident #1 remained in the dining room listening to his music.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further interview with resident #4 revealed one day last weekend (09/07/2024 or 09/08/2024) around 3:30 p. m., he was waiting on S11Certified Nursing Aide (CNA) to return to his room to clean him up and change his brief. Resident #4 revealed S11CNA had gone to go get supplies and was coming back to assist him. Resident #4 reported resident #1 came to the door of his room and told him that he stunk and smelled like poo poo. Resident #4 revealed resident #1 told him you done sh*t yourself and you should be cleaning your own booty. Resident #4 reported resident #1 called him sh*tty boy. Resident #4 reported he notified S11CNA about what resident #1 had told him when she returned to his room to provide incontinent care and change his brief. Resident #4 reported he had not told anyone else about this incident with resident #1 until 09/10/2024 when he informed S5Social Worker.</p> <p>On 09/16/2024 at 11:45 a.m., an interview with S10LPN revealed she worked the night shift on 08/25/2024 and resident #1 was listening to loud rap music on his cell phone in the hallway. S10LPN reported resident #4 was playing on the computer that was located on the hallway by the nurse's station. S10LPN reported she asked resident #1 to turn his music down because there were residents who were asleep. S10LPN reported resident #4 left the computer and went to the main dining room area. S10LPN reported she went to the main dining room a few minutes later to check on resident #4 and observed resident #1 yelling and cursing at resident #4 and threatening to whoop his *ss. S10LPN reported she heard resident #1 call resident #4 a b*tch *ss n*gger, and that he was always complaining like a little b*tch. S10LPN reported S9LPN was already in the dining room and had to intervene to calm them both down. S10LPN reported she immediately called and notified S2Director of Nursing (DON) of the incident.</p> <p>On 09/16/2024 at 10:30 a.m., an interview with S5Social Worker revealed resident #4 came to her office on 09/10/2024 around 2:00 p.m. S5Social Worker revealed resident #4 was reporting that resident #1 was wheeling up to his room, pushing his door open without knocking, harassing him with curse words, and making fun of him that he smells like poop and about his condition. Resident #4 further complained about resident #1 playing loud disruptive music, bowing up to him and saying bad things to him. Resident #1 makes verbal threats by saying he will beat his *ss and the cops. S5Social Worker reported she immediately notified S1Administrator on 09/10/2024 around 2:20 p.m. after talking with resident #4 and initiating a grievance related to resident #4's alleged allegations of how resident #1 was treating him.</p> <p>On 09/16/2024 at 1:00 p.m., an interview with S2DON confirmed she was notified on 08/25/2024 by S10LPN of the incident between resident #1 and resident #4. S2DON further reported she was not informed of the incident between resident #1 and resident #4 that occurred over the weekend (09/07/2024 or 09/08/2024). S2 DON confirmed S11CNA and S10LPN had not notified her of the incident between resident #1 and resident #4.</p> <p>On 09/17/2024 at 1:30 p.m., an interview with S1Aministrator reported she had not been notified of the incident between resident #1 and resident #4 that occur over the weekend (09/07/2024 or 09/08/2024) until S5Social Worker informed her on 09/10/2024. S1Administrator further revealed she had not been notified of the incident between resident #1 and resident #4 that occurred on 08/25/2024. S1Administrator confirmed staff should have notified her and S2DON promptly after the incidents occurred. S1Admininistrator revealed the verbal and mental abuse of resident #4 by resident #1 on 08/25/2024 and over the weekend (09/07/2024 or 09/08/2024) was not reported to the state agency and should have been.</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>41829</p> <p>Based on interview and record review, the facility failed to be in compliance with all applicable Federal, State, and Local Laws, regulations, and codes by S1Administrator response time from residence to facility being over one hour.</p> <p>Findings:</p> <p>During an interview on 09/10/2024 at 10:35 a.m., S1Administrator revealed she lived 1.5 hours away from the facility.</p> <p>Review of S1Administrator's employee file revealed her residence listed was at least a 1.5 hour drive to the facility.</p> <p>During an interview on 09/17/2024 at 1:30 p.m., S1Administrator confirmed that her response time from her residence to the facility was over one hour.</p>